East Sussex Healthcare
NHS Trust

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FOI REF: 23/348

27th June 2023

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Please provide data for each question for the years 2018 - 2022, broken down by calendar year (i.e. 2018, 2019, 2020, 2021 and 2022).

1. Please provide the number of term stillbirths (37 weeks or more) at your trust

Year	Number of term stillbirths
2018	2
2019	1
2020	3
2021	3
2022	2

2. Please provide the review process for each stillbirth recorded, e.g.. X number of PMRTs, X number of SIIs, X number referred to the coroner. If relevant, please include the number that led to no review.

We notify the coroner of all deaths, but none have formally been accepted for HMC review.

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3. **In any reviews done following a stillbirth please list how many times each of the following was a contributing factor, concluded from the investigation.**

   a. **Failing to monitor reduced foetal movements**

   b. **Wrongly interpreting test results during pregnancy**

   c. **Failing to act on test results which highlight a problem**

   d. **Failure to treat infections in the mother**

   e. **Poor staffing levels**

   f. **Failure to notice vital signs of distress**

Year	Number of term stillbirths	a	b	c	d	e	f
2018	2	0	0	0	0	0	0
2019	1	0	0	0	0	0	0
2020	3	0	0	0	0	0	0
2021	3	0	0	0	0	0	0
2022	2	0	0	0	0	0	0

4. **Please provide the number of neonatal deaths at your trust**

Year	Number of NND	Daily Risk	Professional review	Weekly Patient Safety	HSIB Referral	SI	Internal RCA Investigation	PMRT
2018	4	4	2	3	1	0	1	1
2019	1	1	0	0	0	0	0	0
2020	2	2	0	0	0	0	0	0
2021	3	3	2	1	2	2	2	2
2022	2	2	1	1	2	2	1	1

5. **Please provide the review process for each neonatal death, e.g. X number of SIIs, X number referred to the coroner. If relevant, please include the number that led to no review.**

   Please see the table above.

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6. In any reviews following a neonatal death, please list how many times each of the following was a contributing factor, concluded from the investigation.

a. Failing to monitor reduced foetal movements

b. Wrongly interpreting test results during pregnancy

c. Failing to act on test results which highlight a problem

d. Failure to treat infections in the mother

e. Poor staffing levels

f. Failure to notice vital signs of distress

g. Failing in antenatal care

h. Insufficient or inaccurate handovers

i. Failing to recognise need for caesarean

Year	Number of Neonatal Deaths	a	b	c	d	e	f	g	h	i
2018	4	0	0	0	0	0	0	0	0	0
2019	1	0	0	0	0	0	0	0	0	0
2020	2	0	0	0	0	0	0	0	0	0
2021	3	0	0	0	0	0	0	1	0	0
2022	2	0	0	0	0	0	1	0	0	0

7. Please provide the number of maternal deaths at your trust

None.

8. Please provide the number of midwifery staffing red flags at your trust

Year	Number of staffing red flags
2018	We do not hold this information.
2019	14
2020	0
2021	0
2022	22

If I can be of any further assistance, please do not hesitate to contact me.

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Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
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